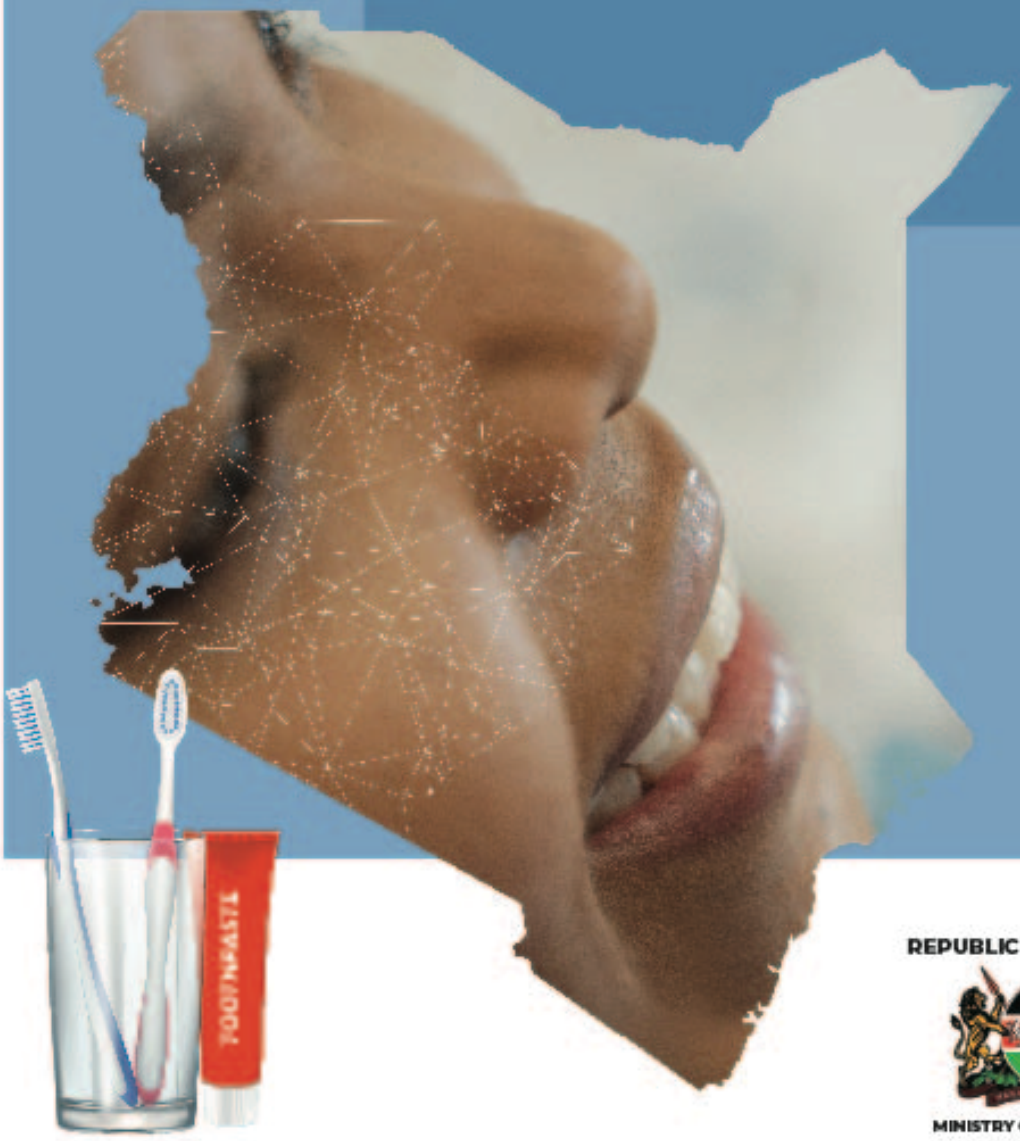
KENYA NATIONAL ORAL HEALTH POLICY

2022 - 2030



REPUBLIC OF KENYA

MINISTRY OF HEALTH

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Nairobi, April 2022

Kenya National Oral Health Policy 2022-2030

Published by:
Ministry of Health
Afya House, Cathedral Road
PO Box 30016 Nairobi 00100

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FOREWORD

The Kenya National Oral Health Policy (2022 – 2030) marks a milestone in the country's progress towards attaining UHC in line with the Constitution of Kenya 2010 and the adoption of the 2030 Agenda for Sustainable Development. In developing this policy, the Ministry has taken cognizance of the current governance structure in the country anchored on devolution of both political and economic power to 47 counties. The new dispensation requires not just a shift in our approach to healthcare services but also forms of engagement with partners within the devolved system of government.

The Government through the Constitution 2010, Kenya Vision 2030 and the UHC Strategy has established an enabling environment for all stakeholders to contribute towards the realization of access to the highest attainable standard of health for all.

The policy recognises that management of oral health in a 'silo' approach will not be effective in tackling the substantial issues highlighted. Instead, integration of oral health promotion and disease prevention into relevant health programmes will enable a unified approach in dealing with the common risk factors. This policy therefore aims to integrate and operationalize oral health within the NCDs, PHC and UHC agendas. The Government appreciates the importance of stakeholder engagement if we are to ensure all Kenyans, including the vulnerable groups, have equal access to essential quality oral health services.

Since most oral diseases are preventable, the policy further seeks to empower communities to take the responsibility of promoting oral health and preventing oral diseases by practicing good oral hygiene and other simple home remedies to reduce the high disease burden. It proposes mechanisms for strengthening existing oral health systems through enhanced governance, financing, infrastructure and human resource to address current oral disease burden.

Further, it is envisioned that this policy will provide a critical reference to all stakeholders, both public and private working towards achieving UHC in Kenya by ensuring that greater attention is given to oral health needs of Kenyans, especially vulnerable groups. This policy will be implemented through the accompanying Kenya Oral Health Strategic plan that has been formulated to ensure effective execution of the policy.

Sen. Mutahi Kagwe, EGH
CABINET SECRETARY

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PREFACE

Oral health is the well-being of the mouth, encompassing many essential functions, including breathing, eating, speaking, smiling and socializing which is integral to overall health, well-being and quality of life, from birth to old age.

Globally, there are estimated to be more than 3.5 billion cases of oral diseases and other oral conditions, most of which are preventable. For the last three decades, the combined global prevalence of dental caries (tooth decay), periodontal (gum) disease and tooth loss has remained unchanged at 45%, which is higher than the prevalence of any other noncommunicable disease.

Cancers of the lip and oral cavity together represent the sixteenth most common cancer worldwide, with over 375 000 new cases and nearly 180 000 deaths in 2020. Cleft lip and palate, the most common craniofacial birth defects, have a prevalence of approximately 1 in 1500 births. Traumatic dental injury is estimated to have a global prevalence of 23% for primary teeth and 15% for permanent teeth, affecting over one billion people.

The personal consequences of untreated oral diseases and conditions including physical symptoms, functional limitations, and detrimental impacts on emotional and social well-being are severe. For those who obtain treatment for oral diseases and conditions, the costs can be high and can lead to significant economic burden.

There is a very strong and consistent association between socioeconomic status (income, occupation and educational level) and the prevalence and severity of oral diseases and conditions. Across the life course, oral diseases and conditions disproportionally affect the poor and vulnerable members of societies, often including those who are on low incomes, people living with disability, refugees, prisoners and/or socially marginalized groups.

Oral diseases and conditions share modifiable risk factors common to the leading noncommunicable diseases, that is, cardiovascular disease, cancer, chronic respiratory disease and diabetes. These risk factors include all forms of tobacco use, harmful alcohol use, high sugars intake and lack of breastfeeding, as well as the human papilloma virus for oropharyngeal cancers. Some of these risk factors are also associated with cleft lip and palate and traumatic dental injury.

The first and only Kenya National Oral Health Survey 2015 reported high oral disease burden. Notable was dental caries in children which was 40%, gum disease over 90% and dental fluorosis 41%. The adult population had over 98% periodontal/gum disease and notable oral cancer and pre-cancerous lesions.

This National Oral Health Policy 2022-2030 will be implemented through 5-year National Oral Health strategic plans. The first National Oral Health Strategic plan 2022-2026 is already developed.

Ms. Susan N. Mochache, CBS
PRINCIPAL SECRETARY

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EXECUTIVE SUMMARY

Oral health is an integral component of general health, quality of life and wellbeing. Good oral health has a positive impact on work productivity, educational performance, growth, development and quality of life. Oral diseases are among the commonest chronic diseases worldwide and constitute a major public health problem due to the resultant affliction as well as the economic burden on individuals, families, societies, and healthcare systems.

The Kenya National Oral Health Policy (2022 – 2030) is an outcome preceded by a situation analysis which revealed gaps in oral health systems including infrastructure, human resource, commodities, supplies and technology. The analysis also documented remarkably high disease burden and enormous unmet treatment needs among the Kenyan population. For instance, according to the Kenya National Survey, 2015, one in every two children aged 5 years suffers from tooth decay.

The aim of this policy is to facilitate the development of comprehensive oral healthcare systems which are integrated into general health (with emphasis on NCDs prevention and control based on PHC principles), education and development policies, towards achieving UHC in Kenya.

To achieve this, the policy will focus on six key objectives as follows:

Objective 1: To strengthen leadership, governance, partnerships and resource mobilization to improve oral health service delivery at all levels.

Objective 2: To strengthen integrated preventive community interventions that address oral diseases and conditions within programmes that influence health using common risk factors approach.

Objective 3: To train and equitably distribute human resource for oral health.

Objective 4: To strengthen health systems capacity to provide oral health services by improving infrastructure and providing equipment, commodities and technologies.

Objective 5: To promote surveillance, evidence-based decision making, monitoring and evaluation, research and information sharing in oral health.

Objective 6: To promote eco-friendly practice of dentistry.

Therefore, I invite relevant stakeholders to join hands with the Government to ensure access and equity in oral healthcare services through the implementation of this policy.

Dr. Patrick Amoth, EBS
AG. DIRECTOR GENERAL FOR HEALTH

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ACKNOWLEDGEMENTS

The development of the Kenya National Oral Health Policy 2022 – 2030 was accomplished through the concerted efforts of various organizations, institutions, stakeholders and experts, who contributed in various ways towards its preparation, editing and publication.

Foremost, I acknowledge the Oral Health Unit, under the Directorate of Healthcare Services (Ministry of Health) and the technical working group led by the Chief Dental Officer, Dr. Miriam Muriithi, which spearheaded the whole exercise.

Secondly, I am particularly indebted to the following stakeholders: Various departments in the Ministry of Health and County Governments especially the NCD, PHC, Community Health services, Quality Standards & Regulation and Policy & Planning; Professional associations – Oral Health Association of Kenya, Kenya Dental Technologists Association, Kenya Dental Association, Kenya Medical Practitioners and Dentists Council; Health Training and Research Institutions – Kenyatta National Hospital, Moi Teaching and Referral Hospital, Moi University, University of Nairobi and the Kenya Medical Research Institute.

Thirdly, I am appreciative of the members of the core writing team: Dr. George K. Kaguru, Ms. Esther W. Kiritu, Dr. Bernard N. Mua, Dr. Regina Mutave, Dr. Miriam W. Muriithi, Ms. Mary Nalyanya, Dr. Olivia A. Osiro and Dr. Jane G. Wamai.

I extend much gratitude to the following for their assistance and contribution: Dr. Lilian O. Apadet, Dr. Salome K. Ireri, Dr. Myrna Kalsi, Dr. George Mwai, Dr. Timothy Theuri and Dr. Linus N. Wachira.

Further, this document would not have been completed without the intense scrutiny and review by a team of technical experts led by Dr. Yuka Makino, Technical Officer Oral Health, WHO Regional Office for Africa.

Others were: Prof Habib Benzian, WHO Collaborating Centre and New York University College of Dentistry; Prof Sudeshni Naidoo, WHO Collaborating Centre and University of Western Cape; Dr. Joyce Nato, Programme Manager, Prevention & Control of NCDs, WHO office, Kenya; and, Prof Poul Erik Petersen, University of Copenhagen.

Finally, special acknowledgement goes to the World Health Organization (WHO) which provided technical and financial support for the planning, development, editing, publication and launch of this National Oral Health Policy.

Dr. Miriam W. Muriithi
HEAD, ORAL HEALTH SERVICES

ABBREVIATIONS

COVID-19	Corona Virus Disease 2019
DMFT	Decayed Missing Filled Teeth (Permanent teeth)
dmft	decayed missing filled teeth (Deciduous teeth)
GBD	Global Burden of Disease
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
LMIC	Low- and Middle-income Countries
MOH	Ministry of Health
NCDs	Non-Communicable Diseases
NHIF	National Hospital Insurance Fund
PHC	Primary Health Care
PLWD	Persons Living With Disability
PPP	Purchasing Power Parity
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
USD	United States Dollar
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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CHAPTER ONE: BACKGROUND

1.1 Introduction

Oral health is defined as the absence of disease and a status that ensures optimal functioning of the mouth and its tissues in a manner preserving the highest level of function and self-esteem. Oral health enables an individual to eat, speak and socialise having no active disease, discomfort or discouragement thus contributing to the general well-being. Good oral health is an essential component of general health and a right of every person[1]. Poor oral health has a negative impact on general health, work productivity, educational performance and adversely affects growth and development.

Several high-income countries have achieved significant improvements in the oral health of adults and children[2]. The African continent, generally comprising low- and middle- income countries (LMIC), has not seen similar changes. Oral health inequities within and between African countries are extensive, mirroring the unequal distribution of resources and exposure to common risk factors of non-communicable diseases (NCDs), inequitable access to health care, as well as widening disparities in socioeconomic status. Over the last five years, there has been emphasis on the role of determinants of health and recognition of common risk factors in the context of the growing burden of NCDs in Kenya. However, oral health was not integrated into the Kenya National Strategy for the Prevention and Control of NCDs 2015-2020[3]. Nonetheless, the strategy is currently under review to embrace the global trend on PHC and UHC, presenting an opportunity for integrating oral diseases into NCDs prevention and control efforts.

The first National Oral Health Survey in 2015[4] revealed a high oral disease burden across all age groups in Kenya. Unmet treatment needs impact negatively on the oral health-related quality of life. Therefore, it is necessary to address the new dynamics of provision of oral healthcare under the devolved system of Government, and in keeping with the aspirations of Kenya's Vision 2030 and the Sustainable Development Goals (SDGs).

This Oral Health Policy (2022-2030) and the related strategic actions outlined in the Kenya National Oral Health Strategic plan (2022-2026) aim to improve oral health by utilizing existing socioeconomic, cultural, political and health system frameworks in the country, underscoring the importance of integration into the plan for prevention and control of NCDs within the context of UHC. It aligns itself with the regional consensus on major strategies around oral health promotion as well as oral disease prevention and control[5]. Additionally, it provides direction on training, skills development, roles and scope of practice of the various cadres of the oral healthcare workforce, while emphasizing the value of oral health research in provisionof evidence-based interventions. This Policy will serve as an important beacon towards realization of improved oral health in Kenya.

1.2 Situation Analysis

1.2.1 Country Profile

The Republic of Kenya is situated in East Africa between latitudes 34° East and 42° West, bordering the Federal Republic of Somalia to the East, Federal Democratic Republic of Ethiopia and Republic of South Sudan to the North, Republic of Uganda to the West and United Republic of Tanzania to the South. The total population enumerated during the 2019 census[6] was 47.5 million, of which 23.5 million were male, 24.0 million were female and 1,524 were intersex. Inter-censual growth rate was established to be 2.2 in 2019[6], a decline from 2.9 in 2009[7]. The current life expectancy for males is 64 years while for females is 69 years. GDP per capita in 2020 was USD 1,838.21[8].

1.2.2 Burden of Oral diseases and conditions

1.2.2.1 Burden of oral diseases and conditions: Global and Regional context

According to the Global Burden of Diseases Study (GBD) in 2019, globally, approximately 3.5 billion people are affected by oral conditions[9]. Untreated dental caries and periodontal diseases are the most frequent conditions. According to the International Agency for Research on Cancer, the estimated age-standardized incidence rate among both sexes of cancer of the lip and oral cavity was ranked 17th globally and within the top three of all cancers among males in some Asian-Pacific countries in 2020[10].

In 2019, more than 480 million people in the African region were estimated to be suffering from oral conditions. Untreated dental caries of permanent teeth is one of the most prevalent diseases regionally, and approximately 25% of the population was estimated to be suffering from decay of their permanent teeth in 2019[9].

In the region, there are six conditions that make up the bulk of the oral disease burden. These are dental caries; periodontal diseases; oral cancers; oral manifestations of HIV infection; oro-dental/facial trauma; cleft lip and palate. Moreover, the spectrum of oral diseases includes noma, which is a necrotizing disease that affects children between the ages of 2 and 6 years. Almost all these conditions are largely preventable or treatable in their early stages[11].

1.2.2.2 Burden of oral diseases and conditions in Kenya

In Kenya, the first National Oral Health Survey of 2015[4], reported the prevalence of oral diseases and conditions as varying from high to low. The most frequent condition was periodontal (gum) diseases affecting almost the entire adult and children population. The overall prevalence of gingival bleeding among children was 75.7% while gingival inflammation was found in 98.1% of the adults examined. The prevalence of dental fluorosis in children was 41.4%. The prevalence of dental caries in adults was 34.3% (DMFT= 0.72).

Other notable conditions affecting the adult population were oral mucosal lesions (20.8%) including oral precancerous conditions such as lichen planus (5.5%) and leucoplakia (6.7%), and oral cancer (0.3%). Prevalence of tooth wear was 14.6%. Other conditions not captured in the survey but equally important include oral and maxillofacial trauma, congenital malformations, oral manifestations of HIV as well as harmful traditional practices and habits in the Kenyan context.

The high level of dental diseases and conditions, like common NCDs, could be attributable to modifiable risk behaviours such as consumption of foods high in refined sugars, harmful traditional practices and habits and, tobacco and alcohol use. From the survey, 17.4% and 19.8% of the adult population reported use of tobacco and alcohol, respectively. The level of knowledge about the importance of oral health seeking behaviour was poor.

1.2.3 Oral Healthcare Systems in Kenya

1.2.3.1 Oral health service delivery, human resource and facilities

Oral healthcare in Kenya is provided by both public and private establishments, more frequently located in urban than rural areas. Access to affordable, quality oral healthcare remains challenging for the majority of Kenyans. Underfunding of such a capital-intensive profession has resulted in inadequate number and poorly equipped public facilities for provision of dental services. Although several private facilities exist, the cost of treatment is a deterrent to many thus leaving a huge proportion of the population with unmet needs.

The emergence of the COVID-19 pandemic resulted in severe global impacts of various facets. Oral health and the practice of dentistry was not spared, requiring an evaluation of current dental service delivery[12]. This necessitates a review of the practice of dentistry moving forward and policy considerations to ensure system preparedness for continuity of quality healthcare.

Low prioritization to implement preventive and promotive oral health programmes has led to the current demand for curative and rehabilitative services outstripping the facilities and human resource available.

Training of oral health workers is done at diploma, undergraduate and postgraduate levels. Although the number of graduates has increased over time, they are inadequate for the oral health needs of the increasing Kenyan population. Kenya provides training for three cadres offering oral health services: the dentist who is the team leader and may be a general practitioner or a specialist; the community oral health officer who provides preventive and minimal non-invasive curative oral health services in the community; and, the dental technologist who constructs or fabricates prostheses or indirect restorations as prescribed by the dentist.

In 2019, the reported number of registered dentists was 1288[6], translating to a Dentist: Population ratio of 3:100,000. The development of an appropriate human resource and equitable distribution of facilities remains a key priority in the promotion of oral health in Kenya.

1.2.3.2 Oral healthcare financing

Over the years there has been a decline in funding for oral health by the exchequer. Following devolution of health services, oral healthcare financing is currently a function of the County Governments. It remains unclear what percentage of the County Government expenditure is specifically allocated to oral health. Most of the oral health treatment expenses is out of pocketand with low insurance coverage.

The health benefit package of UHC provides for limited oral health services. The National Hospital Insurance Fund (NHIF) also covers limited oral health services while private insurances allocate minimal funds towards oral health; furthermore, private insurance premiums are expensive.

1.2.3.3 Leadership and governance

The oral health service at the National Government is headed by the Chief Dental Officer who is responsible for: advising and supporting the Cabinet Secretary for Health on matters relating to dental services and oral health; developing and overseeing the implementation of policy and strategic plan to improve oral health; and, coordination of oral health services in the country.

Oral health policy and training is still a National Government function. Whereas oral health services like other health services is devolved to the County Governments, the structure of oral health governance at the county level is unclear.

1.2.3.4 Integration of oral health into other health programmes

Over the past decades, vertical programming characterized by isolated oral disease management approaches rather than integrated strategies have been the norm. However, it is now generally recognized that oral health promotion, prevention and control of oral diseases should be provided within the context of integrated approaches such as NCDs, PHC and UHC for cost-effectiveness. Oral health has been included in some health programmes; however, the implementation, monitoring and evaluation remains suboptimal.

For example, The Kenya School Health Policy 2021 – 2030 includes components of oral health. However, its implementation and effectiveness have not been evaluated. Further, the School Health Policy promotes safe water and a healthy environment, providing an opportunity for group toothbrushing. Nonetheless, not all schools have implemented the Water, Sanitation and Hygiene (WASH) programme while there is no data on inclusion of toothbrushing within these programmes.

1.2.4 Oral Health Policy Context

The development of this policy is anchored in the Kenyan Constitution and guided by global, regional and local goals, conventions, United Nations political declarations, global action plans and WHO resolutions. The WHO Regional Oral Health Strategy 2016-2025[5] provides clear guidance to accelerate oral health promotion, prevention and control of oral disease by integration of oral health into NCDs towards achieving UHC.

1.2.5 Oral Health Policy Rationale

Kenya, like the rest of the world, is faced with an increase in NCDs including oral diseases. This is due to modifiable common risk factors such as sedentary lifestyle, consumption of tobacco, alcohol and processed foods especially sugars.

Oral diseases and conditions affect close to half the world's population. In Kenya, the disease burden is quite high with childhood caries, adult periodontal disease, an increase in oral cancer and oro-facial trauma, and endemic dental fluorosis.

Low integration of oral health into the PHC, NCD and UHC agendas has not helped the already dire situation. When integrated, oral health will benefit from joint health promotion and disease prevention intervention of these agendas. Inadequate financing for oral health and the scarce human resource in both numbers, skill mix and distribution has further contributed to the neglect of oral health. Oral health is a contributor to general health and well-being and attention to this sector will positively influence the lowering of NCDs, reducing the economic burden and contributing to achievement of UHC.

Therefore, the development of this oral health policy is timely for underscoring the benefits of integrating oral health into existing health programmes. This policy aims to improve the oral health situation of the population and to contribute towards the realization of comprehensive oral healthcare as part of UHC.

1.2.6 Oral Health Policy Development Process

This Oral Health Policy was developed through an evidence-informed and extensive consultative process under the stewardship of the Ministry of Health. Stakeholders comprised government ministries/agencies, development and implementing partners, faith-based organizations, private sector, civil society and registered professional associations.

A comprehensive, critical analysis of global, regional and national status and trends formed the background of the policy. Further, global, regional and national policies, declarations,strategies and surveys including the Kenya National Oral Health Survey Report were also considered during formulation of the policy.

CHAPTER TWO: VISION, MISSION, CORE VALUES, OBJECTIVES, GUIDING PRINCIPLES AND STRATEGIES

2.1 Vision

The highest attainable standard of oral health for the people of Kenya.

2.2 Mission

To provide quality oral healthcare – promotive, preventive, curative and rehabilitative – through an integrated multi-sectoral evidence-based approach for universally accessible and equitable health services.

2.3 Core Values

The custodian of this policy document is the MOH whose core values are:

- Professionalism
- Ethics
- Integrity
- Accountability
- Partnership and collaboration

2.4 Overall Objective

To develop comprehensive oral healthcare systems in Kenya, integrated into general health and based on PHC principles, towards achieving UHC.

2.5 Policy Objectives

i. To strengthen leadership, governance, partnerships and resource mobilization to improve oral health service delivery at all levels.

ii. To strengthen integrated preventive interventions that address oral diseases and conditions within programmes that influence health using common risk factors approach.

iii. To train and equitably distribute human resource for oral health.

iv. To strengthen health systems capacity to provide oral health services by improving infrastructure and providing equipment, commodities and technologies.

v. To promote surveillance, evidence-based decision making, monitoring and evaluation,research and information sharing in oral health.

vi. To promote eco-friendly practice of dentistry.

2.6 Overall Policy Target

The overall policy target is to reduce the oral disease burden. As detailed in Table 1, specifically, the policy seeks to:

i. Upscale oral health promotive and preventive programmes.

ii. Increase access to dental services across all levels of care.

iii. Reduce the prevalence of dental caries across all age groups by 25%.

iv. Reduce periodontal disease by 50%.

v. Reduce dental fluorosis among children by 50%.

vi. Increase awareness on oral cancer.

Table 1: Overall Policy Targets

No.	Indicator	Baseline (2015)	Target by 2030
1.	Upscale oral health promotive and preventive programmes	-	100% of schools implementing standardised school oral health programmes as part of *Health Promoting Schools* initiative
		-	100% of community health promotion and preventive activities have oral health component
2.	Access to dental services across all levels of care	-	100% of level IV and above facilities have a functional dental clinic50% of level III
		-	facilities have a functional dental clinic
	Staff establishment as per MOH Human Resources for Health Norms and Standards[13]	-	25% of health care facilities at all levels of care have staff establishment as per MOH Human Resources for Health Norms and Standards
3.	Prevalence of dental caries among 5-year-olds	46.3%	34.7%
	Prevalence of dental caries among 12-year-olds	17.7%	13.2%
	Prevalence of dental caries among adults	34.3%	25.7%
4.	Prevalence of periodontal disease	98.1%	49%
5.	Prevalence of dental fluorosis among children	41.7%	20.7%
6.	Awareness on oral cancer	-	100% of health education programmes include elements of oral cancer
		-	100% of level IV and above facilities avail screening services for high-risk groups
		-	100% of level IV and above facilities can manage oral cancer cases

2.7 Guiding Principles

To achieve the highest standards of oral health, this policy will be guided by the following principles:

i. **Right to health:** In line with the constitution of Kenya 2010, this policy assures a commitment to the highest attainable standard of oral health. The policy seeks to strengthen oral health systems to deliver quality care that is safe, evidence-based, accessible, equitable and cost effective at all levels.

ii. **Universal Health Coverage:** UHC will ensure that people have access to health care they need without suffering financial hardship. This will increase the access and utilisation of oral healthcare services.

iii. **Social and Commercial determinants**: Oral health inequalities exist in the population due to disparities in income, geographical location, education and other social determinants of health. There is increasing availability and visibility of refined sugars and sweetened beverages, tobacco and alcohol that are detrimental to health, in previously unreached populations. In the absence of adequate oral health prevention measures to address the social and commercial determinants of health, this leads to a marked increase in the burden of oral diseases.

iv. **Equity:** Disadvantaged populations suffer disproportionately from barriers of inadequate oral healthcare. Ensuring access to safe oral healthcare for all populations especially Persons Living With Disabilities (PLWD) is necessary.

v. **Integration:** Oral diseases have shared common risk factors with NCDs. Interventionsin an integrated manner in UHC, PHC and other health related programmes will yield better outcomes among the Kenyan population. Resources will be better utilized to achieve common goals.

vi. **Community participation:** This policy embraces participation of communities in promoting oral health literacy, shared decision making and self-management. Populations are therefore empowered to take care of their oral health at individual, family and community level.

vii. **Evidence-based public health approach:** This policy identifies priority areas and advocates for intervention strategies that will have a higher impact on oral health outcomes at all levels of care if resources are deployed appropriately. Monitoring and evaluation have been incorporated to ensure adequate evidence to support decisions.

viii. **Life course approach:** People are affected by oral diseases and conditions and their risk factors across their life course. There is need to integrate relevant oral health strategies within relevant health programmes targeting different age groups across the life course.

ix. **Partnership:** This policy takes cognisance that oral healthcare requires an integrated approach beyond the services provided by oral healthcare practitioners. The successful promotion and implementation of oral healthcare services will require the involvement of all stakeholders and the community in all stages from the pre-planning stage, implementation to monitoring and evaluation stages.

x. **Technology and Innovation:** Current oral health systems are lacking robust information systems for generation of data to support decision making. This policy proposes to adopt innovative practices utilizing technology to improve availability of oral health data. Inclusion in the Health Management Information Systems (HMIS) is important for oral disease surveillance, monitoring and evaluation.

xi. **Environmental sustainability:** This policy provides recommendations on eco-friendly practice of dentistry to reduce the environmental harm in line with international best practices.

2.8 Priority Interventions

Objective i: To strengthen leadership, governance, partnerships and resource mobilization to improve oral health service delivery at all levels.

i. Review and strengthen leadership and governance structure in oral health across the two levels of government.

ii. Strengthen oral health services in close collaboration with other programmes in the Ministry of Health, other Ministries, and development partners.

iii. Integrate oral health into all relevant policies and public health programmes, including interventions related to NCDs.

iv. Establish a dedicated budget line for oral health.

Objective ii: To strengthen integrated preventive community interventions that address oral diseases and conditions within programmes that influence health using common risk factors approach.

i. Engage the community in planning, implementation and monitoring of appropriate oral health programmes for oral health promotion, oral disease prevention and control.

ii. Promote a healthy diet throughout the life course through a decrease in the consumption of foods and drinks containing high amounts of free sugars.

iii. Promote access to water with appropriate fluoride levels.

iv. Control sale and advertisement of unhealthy products such as alcohol, tobacco and food high in sugar from key settings.

v. Develop and implement integrated school oral health interventions.

vi. Encourage legislation to increase accessibility of quality fluoride toothpaste.

Objective iii: To train and equitably distribute human resource for oral health.

i. Identify and address existing gaps in current training, deployment, distribution and scope of practice of oral health personnel at both levels of government.

ii. Build capacity of oral and non-oral healthcare workers for integrated disease prevention and management.

iii. Build capacity of oral healthcare workers on health records and information systems.

iv. Develop instructional materials on oral health for integration into primary health care.

Objective iv: To strengthen health systems capacity to provide oral health services by improving infrastructure and providing equipment, commodities and technologies.

i. Avail and distribute essential dental equipment and commodities for the management of oral diseases.

ii. Include oral healthcare interventions into the essential benefit packages as a means of achieving UHC.

iii. Improve access to oral health services for vulnerable groups and persons living withdisability (PLWD) as a principle of equity and universal health coverage.

iv. Develop and implement maintenance plans of dental equipment at county and nationallevels.

v. Adopt and support technology to improve oral health care provision.

vi. Establish an oral health emergency preparedness plan.

Objective v: To promote evidence-based decision making, surveillance, monitoring and evaluation, research and information sharing in oral health.

i. Apply international tools for surveillance, monitoring and evaluation of oral health systems.

ii. Conduct operational research in collaboration with partners to inform interventions for the integrated prevention and management of oral diseases.

iii. Integrate systematic collection of oral health data into existing health management information systems.

Objective vi: To promote eco-friendly practice of dentistry.

i. Develop a national plan on phasing down the use of dental amalgam and promotion of mercury-free alternatives.

ii. Promote infection prevention control and safe waste management practices in dentistry.

CHAPTER THREE: ORAL HEALTH POLICY IMPLEMENTATION FRAMEWORK

The Oral Health Policy will be interpreted and implemented in line with the Constitution of Kenya, Kenya Vision 2030 and Health Policy 2014 – 2030 through a multi-sectoral approach. This oral health policy shall be implemented through five-year oral health strategic plans.

3.1 Management and Coordination of the Policy Framework

The Oral Health Policy will be managed in accordance with the overall Health SectorManagement and Coordination Framework, Public Health Act and other related Laws of the Republic of Kenya.

3.2 Leadership and Governance

Oral Health Policy leadership and governance shall aspire towards a comprehensive leadership by the National and County Governments to deliver on the oral health agenda in Kenya. The National Government will provide overall policy direction, strategic leadership and stewardship in defining the vision setting the pace for good governance in the delivery of oral health services.

The Ministry of Health shall establish a Department of Oral Health services to provide leadership and coordination for oral health in Kenya. The county chief dentist will be the oral heath coordinator in every county to lead in oral health matters including implementation of this policy.

The National and County Governments shall mutually consult on services requiring intergovernmental relations for delivery.

3.3 Roles and Responsibilities

3.3.1 Roles and Responsibilities of the National Government

i. Strengthen political commitment at the highest levels to address oral health as one of priority areas as part of NCDs and UHC agendas.

ii. Coordinate with line ministries on oral health promotion and disease prevention.

iii. Develop and implement a multi-sectoral national oral health action plan including a monitoring and evaluation framework for prevention and control of oral diseases.

iv. Establish a dedicated budget line for oral health.

v. Develop sustainable mechanisms to enhance multi-sectoral collaboration and partnerships in the implementation of the priority interventions.

vi. Coordinate the efforts and agenda of several stakeholders in line with country wideNCD, PHC and UHC priorities.

vii. Promote training, recruitment and retention of required oral health workers of theright skills mix and distribution.

viii. Mobilize, involve and empower communities to control and improve their oral and general health.

ix. Conduct research and document lessons on the various aspects of the priorityinterventions.

3.3.2 Roles and Responsibilities of the County Governments

i. Prioritize oral health in the County Integrated Development Plans, Strategic Plans andAnnual Implementation Plans.

ii. Mobilize resources and provide monitoring and evaluation of county oral healthprogrammes.

iii. Support capacity building and provide technical assistance for effective implementationof the policy and other directions from the National government.

iv. Mobilize, involve and empower communities to control and improve their oral and general health.

v. Conduct research and document outcomes on the various aspects of the priorityinterventions.

3.3.3 Roles and Responsibilities of Health Regulatory Bodies

i. Regulate oral health professionals within their area of jurisdiction.

ii. Register and license oral health professionals according to their scope of practice.

iii. Receive and resolve complaints from patients and other parties, and discipline professional misconduct.

iv. Register and licence oral health care facilities.

3.3.4 Roles and Responsibilities of Training and Research Institutions

i. Develop and implement oral health training curricula that meet national and international standards.

ii. Introduce elements of integration and primary healthcare approach in training.

iii. Recommend evidence-based approaches and practices to manage oral diseases.

iv. Conduct and disseminate research on oral health to inform policy implementation.

3.3.5 Roles and Responsibilities of Professional Associations

i. Offer technical advice and professional expertise on oral health matters.

ii. Promote continuous professional development and promote the welfare of oral health professionals.

iii. Maintain professional and ethical standards of oral health services.

3.3.6 Roles and Responsibilities of Media

i. Participate in advocacy and expansion of awareness on matters related to oral health.

ii. Disseminate oral health relevant communication materials.

3.3.7 Roles and Responsibilities of Development and Implementation partners

i. Advocate for increased political commitment at the highest levels to address oral health as part of NCDs and other health programmes using common risk factors approach.

ii. Support the inclusion of basic oral healthcare services into the basic package of services provided by the health and education systems.

iii. Mobilize resources and promoting investment, as well as reinforce public/private partnerships to support integrated national oral health action plans as part of NCDs programmes.

iv. Contribute towards the development, production, and distribution of affordable quality oral hygiene products as well as of quality dental filling materials that are affordable, safe, and eco-friendly.

v. Support operational research to generate evidence for corrective action and continued learning on the relationship between oral diseases and other NCDs and to demonstrate the public health impact, cost-effectiveness and feasibility of interventions.

vi. Increase emphasis on integrated prevention and treatment of oral diseases with NCDs within the context of health professional training curricula at all levels.

3.3.8 Role of Individuals, Families and Communities

i. Promote oral health and disease prevention.

ii. Promote utilization of treatment and rehabilitation facilities by persons suffering from oral diseases and conditions.

iii. Participate in priority setting and service design at the local level.

iv. Participate in community-based oral health programmes.

CHAPTER FOUR: MONITORING AND EVALUATION OFTHE ORAL HEALTH PROGRAMMES

Monitoring and evaluation of the implementation of the Oral Health policy will be through a set of financial and non-financial targets and indicators.

The targets will be in accordance with constitutional requirements, national goals and targets, and health sector priorities elaborated in the Vision 2030, National Health Policy 2014-2030, UHC strategic plan, NCD strategy, PHC Strategic framework 2019-2024, Tobacco Control Policy 2012, National School Health Policy, National Cancer Protocols 2019 and County- specific targets and goals that will be elaborated in the National and County annual plans.

These shall be implemented and monitored through annual work plans and medium-term plans. The targets will be benchmarked against global best practices.

4.1 Monitoring and Evaluation Framework

The collection and management of relevant data will be the responsibility of the Ministry of Health and stakeholders implementing various programmes detailed in the Oral Health Policy. Data will be shared from County to National level through HMIS based on the common database architecture principle.

4.2 Progress Indicators

A core set of indicators for oral health shall be defined in accordance with the policy targets tomonitor and evaluate its implementation.

4.3 Policy Review

This Oral Health Policy shall be reviewed after a period of five (5) years from the effective date. The review process shall involve medium and end term review of the strategic plan by stakeholders at National and County levels. The National Oral Health Taskforce shall providethe guidelines and specify the procedures for reviewing the policy.

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KENYA NATIONAL ORAL HEALTH POLICY

2022 - 2030

Published by:
Ministry of Health
Afya House, Cathedral Road
PO Box 30016
Nairobi 00100

www.health.go.ke

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